HIEPI Business & Technical Operations Workgroup Meeting

Meeting Owners	Bill Baggeroer (WG Lead) Tim Andrews (WG Facilitator)
Minutes Authors	Jackie Baldaro (Governance WG Business Analyst) Diana Quaynor (WG Business Analyst)
Version	1

Date	6/28/10
Time	9 a.m. – 1 p.m. / ET
Location	BROWN 232

AGENDA

Topic "Casting the Net Widely"	Led By	Start	End
OPENING REMARKS – state purpose of meeting, set ground rules for open discussion	Bill	9:00 AM	9:15 AM
Administrative/logistical reminders	Diana	9:15 AM	9:20 AM
Use case discussion, using guidelines outlined in presentation	Tim	9:20 AM	11:30 AM
BREAK	Bill/Tim	11:30 AM	12:00 PM
Options for the state HIE infrastructure and its value to clinical objectives	Tim/Bill	12:00 PM	12:45 PM
CLOSING REMARKS	Tim/Bill	12:45 PM	1:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Bill Baggeroer (NH Lead)	Y	Mary Hunt, PA-C, MHS	Y
Carol Roosa	Y	Patricia Witthaus	N
David Briden	N	Peter Malloy	N
Diana Quaynor (BA)	(phone)	Rebecca Sky	Y
Doris Lotz	Y	Sandy Pardus	Y
Fred Kelsey	Y	Scott Maclean	N
Heidi Johnson	Y	Shawn Tester	(phone)
Hillary St Pierre	(phone)	Theresa Pare-Curtis	N
Kerri Coons	Y	Tim Andrews (Facilitator)	Y
Lorraine Nichols	Y	Trinidad Tellez	Y
Marcella Bobinsky	Y	Wendy Angelo, MD	Y
Mary Beth Eldredge	Y		
Mary Brunette, MD	Y		

GUESTS

Name	In Attendance (Y or N)
Jackie Baldaro (BA)	Y
Mark Belanger (PM)	Y

* Via telephone

MEETING HANDOUTS

1. <<HIEPI Summit 1 Presentation Biz Ops 06-28-10.pdf>>

2. <<NH HIEPI Worgroup Agenda 06-28-10.doc>>

MEETING SUMMARY

Item

1. INTRODUCTIONS/ROLL-CALL – Meeting participants reintroduced themselves to the group. Multiple times throughout the meeting participants were asked if any new members joined the conference call.

2. REVIEW OF OVERALL APPROACH – Facilitator went through a quick overview of the approach discussed in the last meeting.
    a. Goals for today:
        i. Go through the exercise of the checklist of what is happening & categorize building blocks
        ii. Understand what is of high value to this group.
    b. Vision – at a very high level, the overall vision is as follows:
        i. Private & secure
        ii. Promotes quality, safety & efficiency
        iii. Electronic
        iv. Accessible
        v. Equitable
    c. Our charge for the day—ask ourselves:
        i. What are the highest value transactions we can achieve going up the chain of transactions.
        ii. What should we be doing?
        iii. Group to look at the business case for these things too; however, we need to keep our focus on our tasks.
    d. NH HIEPI approach
        i. Use case inventory & prioritization
        ii. Map to HIE building blocks
        iii. Domain-specific considerations
        iv. Phased roadmap
    e. 4 HIE Building Blocks (from least complex increasing to most complex). We're trying to use a common framework and need to group the requirements. More importantly, we're trying not to lose the requirements; we have to translate them to something more reasonable and consumable. However, we should not get too anxious about them. We have some good direction to keep us thinking and talking.
        i. Secure Routing:
            - ***Comment:*** *Consent is a little easier- relationship is there, one way transaction, one way push (a pull is more anonymous are there records out there on my patient).*
            - ***Comment:*** *A lot of secure messaging going on already in NH hospitals, the push is very dense already. Secure messaging*

        ii. Registries & Reporting:
            - ***Comment:*** *Public health reporting is an issue due to current NH State Law. Understood.*
            - ***Facilitator Comment:*** *Patrick is doing the environmental scan. There will be more provided on this.*

        iii. Community record: this is where you can pull information about a patient, or have a shared a community record. Very high value proposition; however, there are business & tech issues to deal with (more global trust issues, more technology, more money, etc…). Terminology translation is another item to include here.
        iv. Shared services: this one is a catch-all; med history, big issues that fall into this bucket.
            - *Discussion*: What other groups/teams are doing: slide 9
            - *Discussion*: Build, Buy, Borrow framework discussed

3. USE CASE DISCUSSION USING GUIDELINE IN PRESENTATION COMBINED W/ OPTIONS FOR STATE HIE INFRASTRUCTURE & ITS VALUE TO CLINICAL OBJECTIVES
    a. **Consolidated Use Case transactions** (Slide 13) discussion:
        - ***Comment****: there were some thoughts expressed about not needing to go through all of these use cases because much of this has already been covered in the state of NH.*
        - The purpose of this activity is to:
            - Get everybody to the table; get broad coverage and then determine what's most valuable. We can speed up or slow down as much as needed.

- Get a list on the table of what is hugely valuable or required from an external force. As lot of the list is already covered—yes, but we need to make sure we at least go through to confirm that on a multi-stakeholder level.
- Stakeholder groups represent all of the state, i.e. what is right for NH. We need to understand what isn't covered from end-to-end of the state, e.g. making sure the North country is covered.
- It could also mean that we decide that a State-level HIE is not the answer. We need to be careful about making assumptions for 100% of all stakeholders when others may need to do something differently.
- It is also our job to align what/how the capabilities get fulfilled not just identify in theory.

b. **Use Cases Planning Exercise** (slide 14 & 15) – the goal to get planning output for each building block. Go through each transaction and do they make sense?
   - ***Comment:*** *An issue was raised regarding structured data – whether CCD or CCR – vs "the story" as captured in text notes as they appear in a discharge note, for example. WG member has the ability to get text notes now and wanted to assure that we didn't lose this in going to a standardized structured document*
     Comment*: As a clinician, I need both for example with a discharge summary. There are holes that need to be filled across the states – CCR vs. CCD or both?? The standard (feds) say you can use either one. We, in NH, can be more restrictive if we choose; however, we need to understand that there may be one system that may not have the capability. 2nd Issue- medical content vs. the CCD structure. There is certain content that we really do not want to lose.*
     Comment: *We already have sharing of text (not losing "the story").*
   - Facilitator defined CCD & CCR for the group—Continuity of Care Document and Continuity of Care Record (episode vs. record).
   - The group began a review of all the use cases:
     - Use Case # 1 – 3: Discharge – there are many different use cases; may have three different use cases; 1) PCP discharge; and 2) ED discharge to another hospital, with specific requirements for mental health, behavioral health & minors; 3) Basic discharge, hospital - hospital, dept-dept is another.
       - ***Comment:*** *there is a huge amount of transfers from small critical care to larger hospital in NH. Need to deal with consent.*
     - Use Case # 4: Departmental reports, e.g. ED Discharge, Radiology report.
     - Use Case # 5 – 7: Public Health – there are zero immunization registries in the state. It may have a manual chart look up; state sends a person to each office and gathers the info from manual reports. **NEW USE CASE:** Parallel set of use cases from the state perspective? <<TAG – LEGAL & POLICY WG>>
     - Use Case # 8: CMS and/or NH Medicaid- Meaningful Use (MU) is PQRI ambulatory only.
     - Use Case # 9: Claims & Eligibility
       - ***Comment:*** *This is one where the state of New York thought was of high value and was a good candidate to have as a shared service. Economies of scale would be achieved; a real sustainability care here if you can get the business entities to agree and there becomes an opportunity to commodity the more basic services. There is an all payer database in NH already.*
     - Use Case # 10: Hospital/Patient Discharge: MU states that it must be made available within 96 hours electronically. An interesting example could be a URL where this information is sent.
       - ***Comment:*** *The Hospital CIOs previously stated that this was a low priority.*
       - ***Facilitator comment****: Yes, understood, however that conflicts with MU. Current workarounds were discussed (PDF's to disk) However how valuable is this and do we want to think about this one more to avoid "workarounds" being used across the state.*
       - ***Comment:*** *current stats indicate that in North Country 95% are not even on EMRs.*
     - Use Case #11, 12: Imaging Reports—this is not part of MU, but its clinical value is quite high. There are two use cases; 1) Getting report; 2) Getting image. Stage 1 MU is all about the push. **NEW USE CASE:** A way to measure Radiation exposure cumulative information when a clinician is ordering scans for patients, along the idea of allergy alerts
     - Use Case #13, #19: Straight forward lab push, lab orders, and integrating more detailed workflow issues providing information about "who will pay for what kind of Lab", recognizing duplicate tests ordering. We need flexibility to integrate more easily with labs.
       - Specific to the state public health lab: **2 NEW USE CASES** for Public Health regarding Lab: 1) pushing lab to provider, provider to lab, public health to/from hosp/ambulatory/labs, the labs themselves; and 2) add a use case for reporting back (lab to public health). This is separate use case for provider workflow using Clinical Decision Support (CDS), which is ABN's (hospitals) high value to providers; routing based upon insurance; and likely out of pocket cost; a high value to providers & pts.

- Huge value for integration of Labs across institutions – there is a sustainability issue where this may support some of the other infrastructure costs. <<TAG - FINANCE WG>>
- There is a definite need to incorporate more lab requirements for MU.

- Use Case #14 & 15: Basic Referrals PCP or Specialist- in NH they can currently send secure email. There is the capacity to open a portal to receive back.
  - ***Comment*** *-Theoretically NHIN direct is looking at this, PCP—Hospital*
- Use Case #16 & 17: Public Health: immunization records, syndromic surveillance data. There is a law that says that we will have a registry in the state of NH. Patient re-identification needs to be discussed. It is complicated and costly.
- Use Case #18: ePrescribing: 75% MU (not controlled substances)
- Use Case #22 & 23: Post visit summary- MU requirement to provide summary of encounter in a CCD and provide patient access to health information within 24 hours.
  - ***Comment:*** *Tracking the uninsured, who are often left out of clinical repositories and so lose continuity of care since they have no plan – suggestion was to make sure we include them as any others and create a "no insurance" plan entry) what is not on the centralized database of demographics on the uninsured (demographic information and to give them a unique identifier). To: ?; From: PCP/hospital/other resources; What: demos'/ CCD; When: encounter/ registration/government; How: ?*
- Use Case #24: Specialist to PCP consult note: same issues—you need CCD & CCR, but "the story" is needed; argument of structured fields vs. free text.
- Use Case #25: Medication history – special attention to issues like the one with Surescripts, whose data we should verify because it is reported that there is as little as 10% of actual fills due to pharmacies not sending fill data and there is no capturing cash fills, etc. Facilitator has heard much better stats elsewhere. **<<Micky/Mark should have good insight from MA>>**
  - ***Comment:*** *Until the technology catches up using the CCD because the usage data from Surescripts is not up-to date,they are unable to get the retailers to send the information back. High Clinical Value: This is very valuable; however, the current mechanisms aren't so good at it. (Group clarified that medication list and medication histories are two different things).*
- Use Case #26: Community Record – multiple sources to hospital/PCP/specialist. Needs an on-demand CCD or CCR.

o Summary of new use cases to be discussed further:
- Use Case # 5 – 7. Public Health: zero immunization registries in the state. It may have a manual chart look up; state sends a person to each office and gathers the info from manual reports. **NEW USE CASE:** Parallel set of use cases from the state perspective? <<TAG – LEGAL & POLICY WG>>
- Use Case #11, 12: Imaging Reports—not part of MU, is clinical value pretty high? Yes, there are two use cases 1. Getting report, 2. Getting image. **Stage 1 MU is all about the push. **NEW USE CASE:** A way to measure Radiation exposure cumulative information when a clinician is ordering scans for patients, along the idea of allergy alerts
- Use Case #13, #19: Straight forward lab push, lab orders, and integrating more detailed workflow issues providing information about "who will pay for what kind of Lab", recognizing duplicate tests ordering. We need flexibility to integrate more easily with labs.
  - Specific to the state public health lab**:** Two **NEW USE CASES** added for Public Health regarding Lab: 1) pushing lab to provider, provider to lab, public health to/from hosp/ambulatory/labs, the labs themselves; and 2) add a use case for reporting back (lab to public health); **this is separate use case for provider workflow using CDS)** Clinical Decision Support (CDS) is ABN's (hospitals) high value to providers; routing based upon insurance; and likely out of pocket cost, which is a high value to providers & pts.
  - Huge value for integration of Labs across institutions – there is a sustainability issue where this may support some of the other infrastructure costs.
  - There is a definite need to incorporate more lab requirements for MU.

4. CLOSE - Discussion of next steps & goals for next meeting.
   a. Keep thinking about use cases and what was missed. Once a good consolidated list is finalized, we will send to the group for review. Then once approved, we will distribute to the other WGs.
   b. Next WG meeting will be a teleconference on July 6th, from 1 – 3pm/ET.

ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Tim	Think about critical and valued use cases for New Hampshire in terms of where we want to prioritize our activities.	All	6/28/10	Ongoing until 7/6
2	Mary Beth	Suggested Collaborative Tools: GoToMeeting and WebEx for T-Cons.	Bill	7/6/10	
3	Diana	Clarify/define some key terms, e.g. ER vs. ED, Mental Health vs. Behavioral Health	All	7/6/10	
4	Tim	Need a parallel set of Public Health use cases from the state perspective	All?	7/6/10	

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1		None			

DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1		None		